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**MEDICAID**

**Factors to Consider in  
Expanding  
Managed Care Programs**

Statement of Janet L. Shikles, Director  
Health Financing and Policy Issues  
Human Resources Division

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## SUMMARY

Medicaid is being severely strained by the continued rise in the size of its population and cost. In 1992, program enrollment is expected to reach 30.1 million, up from 27.7 million in 1991, and program expenditures are to climb to \$127.2 billion in 1992, up from \$92.2 billion in 1991. At the same time this tremendous growth is occurring, however, there is general unhappiness with the traditional fee-for-service Medicaid program. Federal and state policy makers are turning to managed care as a possible way of getting better access and quality for the money they spend.

"Managed care", or "coordinated care" as it is sometimes referred to, is widely used in private sector health care. Generally it refers to a health care delivery system with a single point of entry. A primary care physician participating in the health plan provides basic care and decides when a referral to a specialist or admission to a hospital is necessary.

Our previous reviews of Medicaid managed care programs have identified problems with access to care, quality of services, and oversight of provider financial reporting, disclosure, and solvency. In our work on Chicago health maintenance organizations we reported on incentives to underserve when the financial risk of providing care was passed down to a single physician or group of physicians rather than retained by the HMO as a whole. We also found inadequacies in quality assurance programs, utilization data, and follow-up to correct quality of care problems.

Preliminary results from our current review in Oregon, however, indicate that concerns about these problems can be lessened through oversight and appropriate safeguards. In developing its program, Oregon put a number of safeguards in place to prevent providers from inappropriately reducing service delivery and quality. Client advocates give the program high marks.

Managed care programs can offer an opportunity to improve access to quality health care. Because of the financial incentives of such programs and the vulnerability of the Medicaid population, we believe a set of safeguards must be instituted to assure adequate protection for recipients. These include a quality assurance system that requires client satisfaction and disenrollment surveys; a grievance procedure; and an outside independent review of medical records. Further, states need to monitor subcontracts and utilization data. Finally, effective state and federal oversight is needed along with prompt corrective actions when problems are identified.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to testify on the role of managed care in state Medicaid programs. GAO has been looking at these programs for years and currently has several reviews underway.<sup>1</sup> Based on this work we have gained insights that may be helpful to the Congress as it considers removing barriers to states' use of managed care in the Medicaid program.

#### BACKGROUND

Medicaid, the largest government program financing health care for the nation's poor, is being severely strained by the continuing rise in its size and cost. From 1989 to 1991, total recipients increased almost 18 percent, to 27.7 million. This number is expected to reach 30.1 million in 1992. Just as telling as the rise in people receiving services is the escalation in program costs. For 1992, expenditures are estimated at \$127.2 billion, a 38 percent increase over the 1991 total of \$92.2 billion. Some predictions see Medicaid matching--

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<sup>1</sup>For example, GAO is currently completing its review of the managed care program in Oregon, as it relates to the broader demonstration the state has proposed. We are also conducting a review of Medicaid managed care programs throughout the country. These studies were requested by Reps. Henry Waxman and John Dingell, respectively. Information in this testimony on the Oregon Medicaid managed care program draws on testimony presented in a hearing before Mr. Waxman's subcommittee last fall. ("Managed Care: Oregon Program Appears Successful But Expansions Should Be Implemented Cautiously"(GAO/T-HRD-91-48, September 16, 1991)).

if not exceeding--the size of the Medicare program by the middle of this decade.

At the same time as this tremendous growth is occurring, however, there is a general unhappiness with the traditional fee-for-service Medicaid program. Problems in accessing the health care system can be acute for Medicaid recipients because few providers actively participate. As a result, emergency rooms are used inappropriately--and at a very high cost--as primary care clinics.

Faced with continued growth in the number of Medicaid recipients and program costs, federal and state policy makers are turning to managed care as a way of getting better access and quality for the money they spend. "Managed care", or "coordinated care" as it is sometimes referred to, is widely used in private sector health care. Generally it refers to a health care delivery system with a single point of entry. A primary care physician participating in the health plan provides basic care and decides when a referral to a specialist or admission to a hospital is necessary. Usually the health plan receives a set monthly fee (called a capitation payment) to provide care and is then put at financial risk. That means that if the cost of services provided to an enrollee client is greater than the fee received by the health plan, the health plan loses money.

Managed care plans in Medicaid cover a wide variety of health delivery arrangements. These range from health maintenance organizations (HMOs) that are capitated for providing all health services an enrollee needs, to groups of physicians in independent practice who are paid a small case management fee in addition to fee-for-service payment for managing other services delivered (primary care case management).

GREATER USE OF MANAGED CARE PERCEIVED AS  
WAY TO IMPROVE ACCESS AND QUALITY

In the 1980s, the federal government increased states' options for use of managed care delivery programs as a way to contain costs in the Medicaid program. Although there have been managed care programs in Medicare and Medicaid since the 1970s, the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981 -- P.L. 97-35) gave states greater flexibility in contracting with HMOs or other managed care health plans. In 1982, the Health Care Financing Administration (HCFA) approved Medicaid managed care demonstrations in 6 states. OBRA 1981 also allowed the Secretary of Health and Human Services, through HCFA, to grant states waivers of federal Medicaid rules--specifically, the requirement that recipients have a free choice of providers to permit the states to develop, among other things, managed care systems.<sup>2</sup>

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<sup>2</sup>For this reason, many of the current Medicaid managed care programs are called "freedom of choice" waiver programs. They also may be called "section 1915(b)" waiver programs, referring to the section of the Social Security Act in which they are described.

By 1991, 32 states and the District of Columbia had one or more managed care plans for Medicaid recipients. Medicaid managed care enrollment increased from 187,340 in 1981 to 2,837,500 in 1991, and growth is expected to continue. Approximately 11 percent of all Medicaid recipients currently are enrolled in managed care programs. Of this total 36 percent are in HMOs and 45 percent are in primary care case management fee-for-service programs.

The Administration, facing the same pressures from program growth as the states, is advocating managed care as a potential solution to problems of cost, quality, and access for Medicaid recipients. The President's Comprehensive Health Reform Program presented in February 1992 proposed a radical transformation of the Medicaid program from a fee-for-service system to a managed care system.

SAFEGUARDS AND OVERSIGHT MISSING  
IN CHICAGO MANAGED CARE PROGRAM

To make managed care work, adequate safeguards and oversight are crucial. Our previous reviews of Medicaid managed care programs have identified problems with access to care, quality of services, and oversight of provider financial reporting, disclosure, and solvency.<sup>3</sup> For example, our 1990 report on

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<sup>3</sup>Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans (GAO/HRD-86-10, Nov. 22, 1985); Medicaid: Lessons Learned From Arizona's Prepaid Program (GAO/HRD-87-14, Mar. 6, 1987); Medicaid: Early Problems in Implementing the Philadelphia HealthPASS Program (GAO/HRD-88-37, Dec. 22, 1987); and Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area (GAO/HRD-90-81, Aug. 27, 1990).

Chicago area HMOs participating in managed care under contract to the Illinois Medicaid agency, illustrates the abuses that can occur if safeguards and oversight are not adequate.

One of the major problems we reported was the incentive to underserve. While the incentives inherent in fee-for-service health care may encourage providers to deliver too many services, prepaid managed care may encourage providers to deliver fewer services, and poorer quality services, than enrollees need. These incentives were created in Chicago when some of the HMOs passed through to their subcontractors the financial risk of providing care.

The HMOs were paid a capitated rate by the state for providing care, thus assuming the financial risk of providing the care. In some instances, however, the HMOs subcontracted with medical groups or individual practice associations, who would then contract for services with primary care physicians. At each stage the financial risk of providing care was passed along in the form of a capitation payment. This resulted in a large amount of risk being placed on an individual or small group of physicians, increasing the likelihood that clinical decisions would be inappropriately influenced by the cost of implementing those decisions.

One possible indication that Medicaid recipients enrolled in the Chicago HMOs were having trouble getting needed services was their high turnover rate. Over 58,000 Medicaid recipients voluntarily left their HMOs during fiscal years 1986 through 1988 to return to fee-for-service.

We also found inadequacies in the Chicago HMOs quality assurance programs, utilization data, and follow-up to correct quality of care problems. Although the disenrollment mentioned above could indicate widespread dissatisfaction with the services being provided, the state did not conduct, or have the individual HMOs conduct, patient satisfaction surveys. Despite warnings from both the contracted peer review organization and state quality assurance staff about a lack of services provided to enrollees, the state did not move quickly to determine whether there was a documentation problem or needed services had actually not been provided.

OREGON MANAGED CARE PROGRAM  
AVOIDS INHERENT PROBLEMS

While we found serious problems in the Medicaid managed care program in Chicago, our current review of Oregon indicates that concerns about many of these problems can be lessened through oversight and appropriate safeguards. Oregon's Medicaid managed care program, which began in 1985 with HCFA approval, is generally well accepted by client advocacy and provider groups.

The Oregon program has grown gradually to an enrollment of about 65,000, primarily women and children. The state has contracts with 16 health service providers, with enrollments ranging from 800 to more than 16,000 Medicaid managed care clients. All but one of these providers are capitated for physicians and outpatient services only. Inpatient services for these Medicaid clients are provided on a fee-for-service basis.

In developing its program, Oregon put a number of safeguards in place to prevent inappropriate reductions in service delivery and quality.<sup>4</sup> For example,

-- the state limits the financial risk most providers assume to the cost of physician, laboratory, X-ray, and well-child services;

-- the state provides optional state-sponsored insurance (stop-loss) to limit the financial risk physician care organizations face;

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<sup>4</sup>The state currently has pending with the Secretary of Health and Human Services a proposal to substantially expand its Medicaid program. The demonstration project is designed to expand Medicaid eligibility to all persons with incomes up to 100 percent of the federal poverty level while redefining the scope of health care services the state will reimburse. Services will be provided through a managed care system that is moving toward full service prepaid health plans capitated to provide inpatient as well as ambulatory care. Full implementation is scheduled to begin six months after approval of the proposal.

-- the state pays a capped bonus to participating providers for savings from inpatient utilization below target levels, reflecting treatment decisions made by all physicians, as a group, for all Medicaid patients enrolled in that provider; and

-- the providers have incentive arrangements with their individual physicians based on treatment decisions made by all physicians about all patients.

To ensure adequate quality, Oregon requires providers to maintain internal quality assurance programs and annually conducts an independent review of medical records through a contract with a physician review organization. Further, Oregon assesses quality through client satisfaction and disenrollment surveys, and a grievance procedure.

#### CONCLUSIONS

In conclusion, managed care programs can offer an opportunity to improve access to quality health care. Because of the financial incentives of such programs and the vulnerability of the Medicaid population, we believe a set of safeguards must be instituted to assure adequate protection for recipients. These include a quality assurance system that requires client satisfaction and disenrollment surveys; a grievance procedure; and an outside

independent review of medical records. Further, to reduce financial risks, states need to monitor:

- the financial arrangements between the contracting plan and its individual providers for excessive incentives not to provide necessary services;
- utilization data to determine if the appropriate amount of services are being provided;
- subcontracts in the same manner as contracts because the same problems can arise.

Finally, effective state and federal oversight is needed along with prompt corrective actions when problems are identified.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions.

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